Early Intervention Parenting Partnerships Program Administrative Manual

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Section I: Introduction and Overview of EIPP

Brief Overview of EIPP

The Early Intervention Parenting Partnerships (EIPP) Program is a home visiting program for expectant parents and families with infants who are high need due to practical barriers (e.g., low financial resources, housing instability), emotional and/or behavioral health challenges (e.g., depression, substance use), or other stressors (e.g., immigration-related stress). The goals of EIPP are to:

- Connect families with local resources;
- Provide and build families' social support;
- Appropriately engage families in health care systems;
- Provide parenting education;
- Promote positive parent-child attachment and healthy child development; and
- Support families experiencing multiple stressors to prevent child social and emotional delays, and link with Early Intervention (EI) services where appropriate.

EIPP Structure

EIPP is delivered by a multidisciplinary team of professionals who provide comprehensive services to achieve family and program goals. The core EIPP team consists of the following:

- A Maternal and Child Health (MCH) Nurse;
- A Licensed Mental Health Clinician (LMHC) or Social Worker;
- A Community Health Worker (CHW);
- Nutrition and lactation consultant as appropriate;
- Coordinator; and
- Director.

Pregnant and postpartum parents and their families may enroll until the child's third month, and services continue until the child's first birthday. EIPP participants are provided the following core services: a comprehensive health assessment (CHA); brief intervention[1] including health education and counseling; and, connections with appropriate health care, human services, and resources, as indicated by the assessment and family choice.

Every EIPP participant receives at least one home visit where a CHA is conducted. A CHA is a health assessment in the broadest sense, encompassing the social, emotional, and physical well-being of the pregnant participant, parents, and children in the context of their family. CHAs include at a minimum:

- Clinical assessment with family health history, screening for current or potential factors that impact optimal health, and physical examination as indicated;
- Child feeding status including breastmilk feeding;
- Housing status and safe sleep environments;

[1] Brief Intervention is defined here as recognizing a problem, or potential problem, as soon as possible and mitigating the harm that the problem will cause. It includes creating opportunities to raise awareness, share knowledge, and support a person in thinking about making changes to improve their health.

- Nutritional status, food security, and physical activity;
- Screening for alcohol, tobacco, and other substance use, mental health including postpartum depression, intimate partner violence, and safe environments; and
- Parent-child attachment.

In addition, all EIPP children under the age of one year receive at least one developmental screening utilizing the Ages & Stages Questionnaire third revision (ASQ-3) to assess for developmental delays and EI eligibility (www.agesandstages.com).

The family's strengths and needs are then used to collaboratively develop individualized goals for the Family Care Plan (FCP). After the initial assessment, EIPP providers conduct home visits aimed at connecting the family to resources, providing parent education and skills building support, and facilitating the family's own social support.

Participants are also encouraged to attend a 10-session group designed to build social support by connecting participants with other new and expecting parents. Group sessions also provide education on a variety of maternal and child health and well-being topics such as breastmilk feeding, nutrition, and positive parenting.

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Section II: Staff Roles

The core EIPP multidisciplinary team is comprised of a Maternal and Child Health (MCH) Nurse, a Licensed Mental Health Clinician/Social Worker, and a Community Health Worker (CHW). In addition, appropriate connections with nutrition and lactation consultant services must be assured.

The licensee shall comply with the hiring restrictions established by the Executive Office of Health and Human Services under 101 CMR 15.00: Criminal Offender Record Checks. http://www.mass.gov/courts/docs/lawlib/101-103cmr/101cmr15.pdf

Staff at every level must demonstrate:

a) The ability to form trusting, non-judgmental, and supportive relationships with parents, their children, and other family members; and
b) A respect for diverse family structures, practices and beliefs, particularly related to health and parenting.

Teams are developed to reflect the cultural, linguistic, racial, and ethnic diversity of the population served.

All members of the EIPP team, regardless of discipline, work to provide participants with social and emotional support, education on a variety of health and parenting topics, and connection to community resources. While each EIPP team may differ slightly, responsibilities for all team members generally include:

- Screening and enrolling new participants;
- Providing health education, brief intervention, and social support;
- Promoting participant skills building and problem solving;
- Providing case management and care coordination between participants and other service providers;
- Supporting group services offered through EIPP and reducing social isolation;
- Offering resources and referrals and encouraging connections to other community supports.

Despite many overlapping responsibilities, each role on the multidisciplinary team contributes a unique skill set and area of expertise. Included below are areas of unique emphasis for each role.

Maternal and Child Health (MCH) Nurse
Emphasis on:

- Assessing participant and family needs and strengths guided by the Comprehensive Health Assessment (CHA) and Ages and Stages Questionnaire, Third Edition (ASQ-3)
- Guiding the family in developing a Family Care Plan and identifying priorities for referral and parent education
- Providing counseling on utilization of health systems, prenatal health, breastmilk feeding, nutrition, infant development, physical activity, and healthy environments

Specific Staff Requirements:

- Current licensure as a registered nurse by the Massachusetts Board of Registration, Division of Professional Licensure, with either:
    - A bachelor's degree in nursing from an accredited program, with at least 3 years clinical experience in prenatal, newborn, infancy or maternal services or
    - A Master of Science degree in Nursing in Maternal and Child Health, Family Health or Community Health, or related specialty, and two (2) years clinical experience in prenatal, newborn, infancy or maternal services

Licensed Mental Health Clinician (LMHC)/Social Worker

Emphasis on:

- Assessing participant and family needs and strengths guided by the Comprehensive Health Assessment (CHA) and Ages and Stages Questionnaire, Third Edition (ASQ-3)
- Guiding the family in developing a Family Care Plan and identifying priorities for referral and parent education
- Providing counseling and brief intervention on issues related to mental health, substance use disorders, and intimate partner violence

Specific Staff Requirements:

- Social Work: Current licensure as a Licensed Clinical Social Worker (LCSW) or as a Licensed Independent Clinical Social Worker (LICSW) by the Massachusetts Registry of Social Work
- Psychology: A master's degree from an accredited school of psychology in (a) counseling psychology or clinical psychology, (b) developmental psychology, (c) educational psychology or (d) current licensure as a Licensed Mental Health Counselor (LMHC) by the Massachusetts Board of Allied Mental Health and Human Services Professions, or (e) current licensure as a Licensed Marriage and Family Therapist by the Massachusetts Board of Allied Mental Health and Human Services Professions
- The Mental Health Professional must have a minimum of three (3) years' experience in family counseling with parents of infants
- Additional knowledge and experience in community mental health, infant mental health, substance use disorder (SUD), family violence, and perinatal issues are recommended

Community Health Worker (CHW)

Emphasis on:

- Outreach to families, as well as to local health, mental health, and service organizations
- Mediating between participants, community, and other service providers to assist with educating participants in service systems navigation and educating service providers in meeting the needs of participants
- Assisting participants in meeting concrete needs and connecting to community resources, often accompanying participants in seeking services
- Continued support and engagement through child's first birthday

Specific Staff Requirements:

- Community Health Workers are those who apply their unique understanding of the experience, language and/or culture of the populations they serve to carry out at least one of the following roles:
    - Bridging/culturally mediating between individuals, communities and health and human services, including actively building individual and community capacity;
    - Providing culturally appropriate health education and information;
    - Assuring that people get the services they need;
    - Providing direct services, including informal counseling and social support; and
    - Advocating for individual and community needs (adapted from Rosenthal, E.L., The Final Report of the National Community Health Advisor Study. The University of Arizona. 1998).
- See DPH Policy Statement on Community Health Workers for further information.

Nutrition Consultant
Emphasis on:

- Providing dietary and nutrition counseling

Specific Staff Requirements:

- Current licensure as a Registered Dietician/Nutritionist by the Massachusetts Board of Registration/Division of Professional Licensure with a bachelor's of science degree in nutrition with at least three years of experience working with pregnant and postpartum parents, infants, and their families

Lactation Consultant
Emphasis on:

- Providing support and counseling around breastmilk feeding

Specific Staff Requirements:

- Breastmilk Feeding Specialist who has attained the designation of Certified Lactation Consultant (CLC) from an accredited program such as the Academy of Lactation Policy and Practice with at least two years' experience working with pregnant and postpartum parents, infants, and their families
- Certification as an International Board Certified Lactation Consultant (IBCLC) is preferred

In addition to the core EIPP team, there are a number of administrative and support roles that can exist. While these roles can vary by site, all EIPP teams have a Director and Coordinator.

Director
Emphasis on:

- Providing direct supervision to staff
- Hiring and orienting new staff
- Educating the community about EIPP services, e.g., participating on advisory boards, presenting to local health providers, etc.

- Periodic chart reviews and file checks at discharge
- Administrative and billing oversight
- Facilitating Continuous Quality Improvement (CQI) processes

Coordinator
Emphasis on:

- Coordinating EIPP programming
- Screening and case assignment for new referrals
- Supporting administrative functions such as data collection, entry, and reporting
- Educating the community about EIPP services, e.g., participating on advisory boards, presenting to local health providers, etc.
- Providing direct supervision to staff as appropriate
- Often an existing team staff member fills the role of the Coordinator, combining direct service responsibilities with administrative responsibilities

Section III: Review of Implementation Processes

Implementation supports and drivers are crucial for achieving well-standardized, high-fidelity practices. Establishing a system of strong organizational and leadership support, as well as appropriate competency development pathways for staff, promotes the delivery of high-quality services in line with program standards. These systems can aid the adoption of new practices and ensure sustainability.

Common implementation components include:

- Staff Training that outlines minimum training requirements and structure, training approaches and content, and ongoing professional development standards;

- Fidelity and Process Assessment which includes procedures and processes to measure and document staff fidelity to the model and implementation of services;

- Continuous Quality Improvement, or steps for continual assessment and improvement to the quality of services delivered to participants; and

- Performance Assessment and Data Systems which include data collection processes and measurement systems to document and assess program outcomes and performance.

Along with well-articulated program standards and regular supervision, these components serve to build staff capacity and ensure consistent service delivery across a variety of providers and settings.

Section IV: EIPP Standards of Care

Introduction

Description of this Section

This section describes the standards of care for the EIPP Program. Beginning with an overview of the goals and objectives, the document then presents each goal with its corresponding standards of care.

This section will be reviewed with EIPP vendors, EIPP funders, and other perinatal and early childhood experts as needed, and changes will be made as necessary.

This guide should be used in conjunction with other program documents:

- DPH EIPP Request for Responses (RFR)
- Your vendor-specific contract
- EIPP Practice Manual
- EIPP Data Manual
- EIPP Billing Guide

Desired outcomes for the program are:

- Improved maternal health and perinatal outcomes;
- Optimal child growth and development through the first year of life.

To achieve these outcomes, EIPP has the following goals:

Goal 1: Improve access to and utilization of health care services.
Goal 2: Improve nutrition, physical activity, and breastmilk feeding initiation and duration rates.
Goal 3: Ensure a safe and healthy social, emotional, and physical environment.
Goal 4: Strengthen local perinatal and early childhood systems through collaboration with community entities and active engagement of families.

These four goals are evaluated by the following Performance Measures:

1. Percentage of EIPP participants served by the program who were enrolled prenatally.
2. Percentage of families served by the program who had at least five visits by program discharge.
3. Percentage of families served by the program who had a Comprehensive Health Assessment (CHA) completed by the end of the second face to face visit.
4. Percentage of families with a concern identified on a CHA who received education and/or a brief intervention.
5. Percentage of participants who gave birth and had a postpartum visit with a health care provider between 21 and 56 days after birth.
6. Percentage of children who had a 2-month Ages & Stages Questionnaire completed with the child's primary caregiver(s).

7. 7A. Percentage of children who were fed exclusively breast milk at birth.
7. 7B. Percentage of children who were fed any amount of breast milk at 6 months postpartum.
8. Percentage of EIPP participants who had a documented reproductive life plan that included family planning counseling and choice of contraception by 2 months postpartum.
9. Percentage of EIPP participants who were screened for depression using the Edinburgh Postnatal Depression Scale (EPDS) within 70 days of enrollment.
10. Percentage of EIPP participants identified with depression and/or other mental health condition on the CHA and/or EPDS who received mental health services by program discharge.
11. Percentage of EIPP participants who were screened for intimate partner violence (IPV) using a validated screening tool within 70 days of enrollment.
12. Percentage of EIPP participants who were screened for alcohol, tobacco, and other drugs (ATOD) using a validated screening tool within 70 days of enrollment.
13. Percentage of children who were most often placed to sleep on their backs.

Guiding principles

EIPP Standards of Care describe program requirements, and are used as criteria by the Massachusetts Department of Public Health for program monitoring and quality assurance. The EIPP Standards and all Massachusetts EIPP vendors incorporate in their practice the following guiding principles:

Respect

Respect that every family has their own unique culture and EIPP honors the values and ways of each family's neighborhood, community, and extended family.

Individualization

Supports and services will be tailored to each family to meet its own unique needs and circumstances.

Educational materials and services will be provided in a manner and format that best meets cultural, linguistic, cognitive, literacy and accessibility needs of the participants. Programs will make every attempt to hire staff that is representative of the population being served.

Translation/Interpreter services will be provided or bilingual staff will be available.

Family Centeredness and the Family Care Plan (FCP)

EIPP services are guided by the family care plan (FCP), which is developed by the family in collaboration with the EIPP team. The FCP is based on family strengths, needs, and resources, as identified through the CHA and completed with the family by the end of the second unit rate reimbursed home visit.

The FCP is a working document that contains the agreed upon EIPP services. It is updated as appropriate and produced collaboratively by program staff and the participant.

Family care plans clearly define the family's concerns, priorities, resources, estimated timeframe for reaching goals, and the responsibilities of the EIPP team and the family in working toward meeting the goals.

Community
EIPP recognizes that each family exists in the context of a greater community, and fosters these communities as resources for supports and services.

Team Collaboration
EIPP works as equal partners with each family and with the people and service systems in the family's life.

Life-long Learning
EIPP supports and services are viewed as a first step in a journey for each pregnant participant, parents, children, family, and provider.

Goal 1: EIPP will Improve Access and Utilization of Health Services

Standards and Criteria
Standard 1.0: Families served by the program have a completed Comprehensive Health Assessment (CHA).

Criteria:

1.1 The CHA is a health assessment in the broadest sense encompassing the social, emotional, and physical well-being of the pregnant participant, parents, and children in the context of their family.

1.2 The CHA includes relevant participant and family health history, screening for current or potential factors that impact optimal health, and physical examination as indicated.

1.3 The CHA includes screening for access to primary health care including prenatal care, medical and mental health services, WIC and other nutritional support, economic support, risk of homelessness, and help with meeting basic needs, education and job training, recreational opportunities, and specialized programs as needed, such as treatment for substance use disorder, intimate partner violence, or legal services.

1.4 Health assessments include the protocol listed under the standards for Breastmilk Feeding, Nutrition, Physical Activity, Mental Health, Alcohol, Tobacco, & Other Drugs (ATOD) use, Intimate Partner Violence, and Health and Safety.

1.5 At enrollment, the MCH Nurse or the LMHC/Social Worker conducts the initial CHA.

1.6 After birth and until 12 months of age, the MCH Nurse or LMHC/Social Worker conducts the CHA and developmental screenings for probable eligibility for EI at key developmental stages.

1.7 Developmental screenings are conducted using the Ages and Stages Questionnaire, third revision (ASQ-3). The ASQ-3 is used to observe child behavior and intervene with parents around issues of child development, attachment, and behavior.

1.8 The CHA and the ASQ-3 must be completed within a four week timeframe of when due. This four week timeframe is two weeks before and two weeks after the due date for completion of the CHA and ASQ-3.

1.9 The MCH Nurse or LMHC/Social Worker conducting the CHA and developmental screenings, either employed directly or indirectly by an Early Intervention program (including salaried, contract/fee for services, or consultant/subcontract), is certified as an Early Intervention Specialist by the Massachusetts Department of Public Health (for more information refer to Early Intervention Operational Standards, July 2013).

1.10 The CHA and developmental screening are conducted at least two times by 12 months of age.

1.11 Parents are encouraged to be actively involved in the screening, and are respected as the persons with the most knowledge of their child's attributes and abilities.

1.12 Information gained through the screening process is used as the basis for fostering optimal parent-child interactions and activities which promote healthy child development.

1.13 Early Intervention staff will review screening results for potential eligibility for Early Intervention.

Standard 2.0: Families receive health education, brief intervention, and counseling appropriate to the families' needs and based on the CHA.

Criteria:

2.1 Health education, brief intervention, and counseling are family-centered and provided in response to family concerns identified on the CHA.

2.2 Brief interventions raise awareness, share knowledge, and support a person in thinking about making changes to improve their health. It is done for any behavior which affects health, for example, diet, exercise, personal hygiene, unprotected sexual intercourse, smoking, excessive drinking of alcohol, use of other substances. What is done during a brief intervention depends on the person, the setting, whether the person is ready to change, and whether you are building on previous interactions.

2.3 Health education is provided in coordination with the family's health care provider(s).

2.4 Health education includes importance of prenatal, postpartum, and primary health care.

2.5 Health education includes health topics including cardiovascular health, diabetes, breast and cervical cancer, and other topics as indicated.

2.6 Health education includes reproductive and sexual health including family planning, contraception choice, and STI risk reduction.

2.7 Health education includes preparation for child birth consisting of planning for hospital stay, anatomy and physiology of pregnancy and birth, physical and emotional changes related to pregnancy, danger signs of pregnancy, signs and symptoms of preterm labor, preparation for labor and birth and postpartum changes.

2.8 Health education includes parent-child attachment and bonding.

2.9 Health education includes information on child crying, child soothing techniques, shaken baby prevention, safe sleep practices, etc.

2.10 Health education includes planning for parenthood and the impact on other family members.

2.11 Health education includes self-care and stress management techniques.

2.12 Health education includes normal child growth and development.

2.13 Health education includes all routine child screenings and appropriate referrals.

2.14 Health education includes the importance of age-appropriate immunizations.

2.15 Health education includes the topics described in the standards for breastmilk feeding, nutrition, physical activity, mental health, ATOD use, intimate partner violence, and health and safety.

2.16 Health education includes how to recognize and respond to an emergency including:
- How and when to call an emergency provider including fire, police and medical; and
- Learning signs and symptoms of complications and how to access emergency care.

2.17 With the participant's approval, partners, significant others, and other household members are encouraged to participate in the education process.

Standard 3.0: EIPP facilitates families' access to reproductive, primary and pediatric care, and other community services.

Criteria:

3.1 Participants are supported in attending their postpartum visit with their obstetric provider between 21 and 56 days after birth.

3.2 Families receive information and support on selecting a primary care provider, when appropriate.

3.3 Families are provided with self-advocacy tools to be full partners in their health care.

3.4 The program follows up with the participant's referral source and/or service provider to determine if the participant received needed services.

3.5 Families are supported in accessing and maintaining health insurance.

3.6 Families are supported to access necessary services as identified through the CHA and FCP.

Standard 4.0: Families are provided with reproductive health education and counseling including family planning and STI prevention.

Criteria:

4.1 Home visitors are knowledgeable, objective, and nonjudgmental about reproductive health including family planning and STI prevention.

4.2 Counseling is designed to strengthen decision-making skills, to promote healthful behaviors, and to help participants make informed choices about family planning and contraception.

4.3 At a minimum, family planning counseling is discussed by the third trimester and within one month postpartum.

4.4 Families are supported in developing a reproductive life plan that includes a set of goals specific to having or not having any more children, pregnancy spacing, contraception choice, preventing pregnancy until ready, and improving overall personal health.

4.5 Education and counseling are given based on participant need and are available on reproductive health including basic reproductive anatomy and the importance of self-examinations.

4.6 Education and counseling are given based on participant need and are available on family planning services including contraceptive use and the value of fertility regulation in maintaining individual and family health.

4.7 Education and counseling includes STI risk reduction and disease prevention.

4.8 Families are supported in making and accessing a contraception choice by two months postpartum.

Goal 2: Improve Nutrition, Physical Activity, and Breastmilk Feeding Initiation and Duration

Standards and Criteria

Standard 5.0: Families are provided with breastmilk feeding education and support services.

Criteria:

5.1 EIPP lactation consultation services are offered to all postpartum participants.

5.2 With the participant's approval, partners, significant others, and other household members are encouraged to participate in breastmilk feeding education and goals.

5.3 Prenatal breastmilk feeding education includes instruction on initiating and maintaining adequate milk supply, proper positioning and latch techniques as well as anticipatory education on health benefits of breastmilk and common barriers to breastmilk feeding success (physical, social and emotional).

5.4 Prenatal breastmilk feeding education and support includes at least two face-to-face contacts.

5.5 Breastmilk feeding support includes assessment of feeding techniques and adequacy of child milk intake for the comfort of the participant and optimal growth of the child.

5.6 Postpartum breastmilk feeding education and support includes a phone contact with family within 48 hours of discharge or a visit within forty eight hours post hospital discharge.

5.7 Postpartum breastmilk feeding education and support includes an assessment of current feeding status and breastmilk feeding technique, counseling consistent with the participant's breastmilk feeding goals, and referrals to local breastmilk feeding support groups or other support sources as needed.

5.8 Breastmilk feeding education and support continues in all contacts made with the postpartum participant and child throughout program eligibility, as long as the participant continues to see the MCH Nurse.

5.9 Support and referrals for pumping of breastmilk are provided to breastmilk feeding participants needing to be separated from their child, such as those who return to work or school.

5.10 If the family is enrolled in WIC, with the family's consent, the program coordinates and collaborates with the breastmilk feeding coordinator, CLC, or IBCLC on staff.

Standard 6.0: Families are provided with nutrition education, physical activity education, and support services.

Criteria:

6.1 EIPP nutrition consultation services are offered to all participants. The Nutrition Consultant is certified as an Early Intervention Specialist by the Massachusetts Department of Public Health (for more information, refer to the Early Intervention Operations Standards, July 2013).

6.2 Support and education promotes maintenance of a healthy weight and appropriate weight gain in pregnancy.

6.3 Support and education include the importance of regular physical activity upon physician's approval.

6.4 Prenatal nutritional assessment includes monitoring weight gain at each visit.

6.5 Prenatal education includes:
- Personal good nutrition and anticipatory education on barriers to personal good nutrition;
- Safe and appropriate physical activity during pregnancy; and
- Child feeding with support of breastmilk feeding as the optimal child feeding method unless medically contraindicated.

6.6 Food security is assessed with referrals made to WIC, SNAP benefits, food pantries, and other resources as appropriate.

6.7 Participant nutrition education and referral includes an assessment of current nutritional status.

6.8 Participant nutrition education includes education on personal good nutrition and food availability.

6.9 Child nutrition education and referral includes an assessment of child's current nutritional status.

6.10 Child nutrition education includes guidance on:

- Stages of child feeding;
- Development of child feeding skills; and
- Nutritional needs for positive growth.

6.11 Guidance is provided on safe child settings that facilitate age-appropriate physical activity and development of movement skills and that do not restrict movement for prolonged periods of time.

6.12 Referrals to local nutrition services and medical care are provided as needed.

6.13 If the family is enrolled in WIC or other nutritional programs, with the family's consent, there is coordination with the nutrition and breastmilk feeding staff.

Goal 3: Ensure a Safe and Healthy Social, Emotional, and Physical Environment

Standards and Criteria

Standard 7.0: Families are screened for Alcohol, Tobacco, and Other Drugs (ATOD) and provided education about the associated risks.

Criteria:

7.1 Participants are screened for ATOD within 70 days of enrollment, at key postpartum stages, and as appropriate.

7.2 Tobacco education includes the dangers of tobacco use, second and third hand smoke.

7.3 Existing tobacco cessation supports are made available to all participants' family members or household members.

7.4 Information and education include the associated risks with ATOD use during the perinatal and early childhood period.

7.5 Home visitors routinely screen for alcohol and other substances using the screening tool on the CHA.

7.6 Immediately after any disclosure of substance use or risk of use, home visitors assess dependence, amount, effects, and loss of control.

7.7 Home visitors utilize the brief intervention model and motivational interviewing techniques including stating medical concern and developing a plan of action with participant.

7.8 Participants' Stage of Change is reviewed at each contact in order to offer the appropriate level of service.

7.9 Referrals are made to the Massachusetts Substance Abuse Helpline (800-327-5050), Massachusetts Smokers Helpline (800-784-8669) and other specialized addictions services and ongoing supports if needed.

7.10 Letters of affiliation with local substance abuse services are obtained that describe EIPP's role as a connecting and referral source to substance abuse services and after-care plans.

Standard 8.0: Families are screened for, and given information on, health and safety.

Criteria:

8.1 Education is provided regarding the prevention of major childhood injuries including proper use of car seats, safe sleep environment, reduction of risk for SIDS, fire and the importance of working fire detectors, falls, poisoning, choking, drowning, shaken baby syndrome, sun safety, safe environments, and other issues as needed.

8.2 Participants are screened for how they most often place their child to sleep on their back by 70 days postpartum.

8.3 Information is provided on necessary and safe child supplies and equipment.

8.4 Vendors subscribe to the US Consumer Product Safety Commission's email list to receive regular recalls involving products that present a risk to children.

8.5 Education includes lead poisoning prevention and environmental asthma management.

8.6 Any safety concerns regarding landlord/tenant issues are referred to housing assistance or legal services.

8.7 If there is any peeling/chipping paint, a referral to the DPH Lead Poisoning Prevention program is offered to the family.

8.8 Families are made aware of the Regional Center for Poison Control and Prevention's toll-free number: (800) 222-1222.

8.9 Local resources for car seats and car seat technicians are provided to families.

8.10 Local resources for cribs and safe sleeping environments are provided to families.

Standard 9.0: Families receive information on and support for emotional health and healthy parenting

Criteria:

9.1 The CHA includes an assessment of past or present mental health concerns. Referral indicators include:
- Postpartum depression screening which necessitates follow-up;
- Concern about the physical safety of any family member;
- Psychosocial or mental health issues which seem to be interfering with the client's ability to benefit fully from program services;
- Participant's expression to have counseling for personal issues; and
- Participant demonstrates need for short-term support to deal with change in life circumstances (i.e., grief, transitions, situational stress).

9.2 The Edinburgh Postpartum Depression Screening (EPDS) tool is utilized with participants within 70 days of enrollment, at key postpartum stages, and as appropriate based on the participant's mental health status.

9.3 Referrals are made to mental health services when postpartum depression or other mental health concern is identified through screening.

9.4 Referrals are made to the Postpartum Support International (PSI) of Massachusetts Warmline (866-472-1897), Parental Stress Hotline (1-800-632-8188), and other specialized mental health services if needed.

9.5 Families are made aware of the Massachusetts New Parent Initiative resources including digital stories at www.mass.gov/dph/newparent, the Massachusetts Postpartum Depression Initiative resources at www.mass.gov/postpartum-depression and the Massachusetts Mental Health Initiative materials downloadable at www.maclearinghouse.com.

9.6 Emotional Health and Parenting education is provided on relevant topics such as:
- Recognizing signs of stress and learning appropriate coping mechanisms;
- Appropriate expectations;
- Understanding child cues;
- Building and maintaining self-esteem;
- Supporting healthy communication skills and healthy relationships including decision making, negotiation skills, and parenting discipline; and
- Developmentally appropriate play and learning.

9.7 Support is given to the parent-child relationship through proactive prenatal interventions such as preparing for the child, preparing to parent, developing a nurturing parent-child relationship, and healing past parental trauma and losses.

9.8 Education is provided on parent-child attachment and bonding.

9.9 Referrals are made to parent support and counseling services.

9.10 Home visitors participate in care coordination or multi-disciplinary service teams as necessary per participant.

9.11 Staff advocate for participants who need assistance in accessing mental health services.

Standard 10.0: Families are informed, screened, and assessed for intimate partner violence.

Criteria:

10.1 All participants are informed about healthy and unhealthy relationships.

10.2 All program staff is trained on agency policy and procedures specific to suspected intimate partner violence prior to implementing screening protocols.

10.3 Home visitors identify community resources for intimate partner violence and sexual assault prior to implementing screening and assessment protocols.

10.4 Participants are screened for intimate partner violence within 70 days of enrollment, at key postpartum stages, and as appropriate.

10.5 Screening is confidential. Prior to screening, participants are informed of any reporting requirements or other limits to provider/participant confidentiality.

10.6 All participants are screened routinely for current and lifetime exposure to intimate partner violence including direct questions about physical, emotional, and sexual abuse.

10.7 Screening should NOT occur unless it can be conducted in private: no friends, relatives (except non-verbal children), or caregivers should be present or in the house.

10.8 Initial health and safety assessments occur immediately after disclosure. The goals of the assessment are to provide the participant with information and choices so that the participant can make informed decisions about health and safety.

10.9 Follow-up screenings and repeat assessments occur during all subsequent appointments as appropriate.

10.10 Interventions with victims of violence will be based on the severity of the abuse, the participant's decisions about what assistance is desired at that time, and if the abuse is happening currently. Interventions include:

- Initial safety planning;
- Referrals to local advocacy and support systems within the health care setting and community;
- Referrals for children who witness violence;

- Referrals to community based domestic violence programs for expanded safety planning;
- Utilization of the Rape Crisis Center hotline by region of the state. Hotline numbers can be located at https://www.mass.gov/service-details/rape-crisis-centers; and
- Utilization of the SAFELINK Domestic Violence Hotline, 1-877-785-2020.

10.11 Support and help are offered regardless of whether the participant decides to stay in or leave the relationship.

10.12 Resource brochures should be left if a participant is agreeable and feels safe having the information left with them.

10.13 Participants are given information about how to obtain a 209A restraining order, and appropriate referrals are made to victim-witness advocates through the local District Attorney Office or local domestic violence program for assistance with restraining orders, or other legal issues.

10.14 Children who witness violence are assessed to determine whether mental health intervention is necessary, and if so, which services are appropriate.

10.15 Agencies have a written policy for staff in regards to mandated reporting issues involving intimate partner violence they witness or detect in the families they serve.

Standard 11.0: Families are informed, screened, and assessed for child abuse and neglect.

Criteria:

11.1 The program develops and maintains written procedures for addressing any suspected incident of child abuse or neglect. It includes, at a minimum:
- Staff report suspected child abuse or neglect to the EIPP Director or designee and Department of Children & Families pursuant to M.G.L. c 119§51A; and
- The EIPP Director or designee will notify the Department of Public Health, EIPP Services, immediately after filing a 51A report, or learning that a 51A report has been filed, alleging abuse or neglect of a child while in the care of the program, or during a program related activity.

11.2 All program staff is trained on agency policy and procedures concerning suspected child abuse and neglect prior to implementing screening protocols.

11.3 All families involved in the program are screened for current and lifetime exposure to child abuse and neglect.

11.4 Screening is confidential. Prior to screening, participants are informed of any reporting requirements or other limits to provider/participant confidentiality.

11.5 Initial safety assessment occurs immediately after disclosure. The goal of the assessment is to:
- Create a supportive environment in which the participant can discuss the abuse and/or neglect; and
- Enable the provider to gather necessary information in order to appropriately develop and implement a response.

11.6 Support and help are offered including, but not limited to, referrals to local social support and counseling services as needed.

11.7 The program develops and maintains written procedures for addressing any suspected incident of child abuse by professional staff that includes, but is not limited to, ensuring that an allegedly abusive or neglectful staff member does not work directly with children until the Department of Children & Families investigation is completed or for such a time as the Department of Public Health requires.

Goal 4: Strengthen Perinatal and Early Childhood Systems through Community Collaboration and Family Engagement.

Standards and Criteria

Standard 12.0: The EIPP establishes or continues a committee that advises on perinatal and early childhood health.

Criteria:

12.1 The committee assists in on-going program planning, development, evaluation, and sustainability. This body includes representatives from relevant community stakeholders, such as birth hospitals, health care, mental health, and social service providers, WIC sites, child care services, Healthy Families Program, Parent as Teachers, Early Intervention, Early Head Start programs, schools, community development organizations, local businesses, religious and cultural organizations, as well as participating and/or eligible families, and other residents of the community(ies) served.

12.2 The committee meetings are held at least three times annually. Meeting minutes and participant attendance lists are maintained by program staff.

12.3 Program staff should make every effort to coordinate with other perinatal and early childhood health programs to ensure coordinated advisory committee bodies that serve all programs.

12.4 Staff must attend appropriate community collaborative meetings to develop strong referral mechanisms, identify community needs, and advocate for and improve available resources.

Standard 13.0: Staff has the required training and competencies.

Criteria:

13.1 All MCH Nurses will maintain expertise on childbirth education including:
- Planning for hospital stay;
- Anatomy and physiology of pregnancy and birth;
- Physical and emotional changes related to pregnancy;
- Warning signs of pregnancy including signs and symptoms of preterm labor; and
- Preparation for labor and birth and postpartum changes.

13.2 All MCH Nurses will maintain expertise on health issues including the ability to counsel and assess for issues such as:
- Healthy weight and physical activity;
- Cardiovascular health;
- Diabetes;
- Asthma;
- Breast and cervical cancer; and
- Reproductive health and family planning.

13.3 All MCH Nurses are trained on conducting a physical assessment and a medical history.

13.4 All MCH Nurses are trained on conducting a child developmental screening using the Ages & Stages Questionnaire. In addition, all MCH Nurses will maintain expertise in parent-child interaction and teaching points with parents around child development and behavior.

13.5 All LMHC/Social Workers will maintain expertise on brief intervention techniques and understanding stages of change related to alcohol, tobacco, and other drugs.

13.6 All LMHC/Social Workers will maintain expertise on perinatal mood disorders.

13.7 All LMHC/Social Workers will maintain expertise on cognition and perception.

13.8 All LMHC/Social Workers will maintain expertise on intimate partner violence.

13.9 All LMHC/Social Workers are trained on conducting a child developmental screening using the Ages & Stages Questionnaire. In addition, all LMHC/Social Workers will maintain expertise in parent-child interaction and teaching points with parents around child development and behavior.

13.10 All Community Health Workers will maintain expertise on health insurance benefits and eligibility.

13.11 All Community Health Workers will maintain expertise on Department of Transition benefits including Emergency Assistance and SNAP.

13.12 All Community Health Workers will maintain expertise on Department of Housing and Community Development benefits including available housing resources.

13.13 All Community Health Workers will maintain expertise in relevant community resources and concrete supports such as food, clothing, furniture, etc.

13.14 All Community Health Workers will maintain expertise in parent-child interaction and teaching points with parents around child development and behavior.

13.15 All Lactation Consultants will maintain expertise in the clinical management of breastmilk feeding and lactation including:

- Prenatal counseling;
- Basic position and latch;
- Preventing and managing common concerns such as poor latch, inadequate milk supply, and nipple pain;
- Strategies for breastmilk feeding and lactation after returning to work; and
- Breastmilk feeding in challenging situations such as with multiples or a preterm child.

13.16 All Nutrition Consultants will maintain expertise in perinatal and child nutrition including the promotion of a healthy metabolism, good immune response, and a healthy body weight taking into consideration individual food preferences and culture.

13.17 All EIPP Supervisors maintain expertise in reflective supervision.

13.18 All staff are trained to:

- Recognize the spectrum of postpartum mood disorder symptoms through questions and observation of the participant, child, and family; and
- Assess parent-child attachment and parenting skills.

13.19 All staff are trained to:

- Understand the dynamics of intimate partner violence, the safety and autonomy of abused individuals, and elements of culturally competent care;
- Know the range of services available through local domestic violence programs and rape crisis centers as well as through hospital- or community health center- based violence prevention programs;
- Know how to ask about whether someone has experienced violence and/or other types of abuse and respond with appropriate information, including initial safety planning, and referrals to local community resources as appropriate;
- Identify signs of and risk factors for child abuse and neglect; and
- Understand mandatory reporting laws for children, elders, and those with disabilities and methods that can be employed to more safely report when necessary.

13.20 All staff are provided with skill development training in the following topic areas:

- Motivational interviewing;
- Written and oral communication skills;

- Relationship based engagement;
- Safety and de-escalation;
- Trauma informed care including secondary trauma prevention and self-care;
- Continuous quality improvement;
- Professionalism and boundaries; and
- Racial equity and implicit bias.

13.21 All staff are provided with foundational content training in the following topic areas:

- Breastmilk feeding;
- Child development;
- Healthy parenting;
- Child and parental nutrition;
- Injury prevention;
- Immigration rights;
- Lead law and family rights;
- Oral health;
- Physical activity;
- Substance use; and
- Mental health.

13.22 All staff is trained on the Agency Workplace Violence Prevention and Crisis Response Protocols in compliance with Section 30 of Chapter 3 of the Acts of 2013 and Executive Order 442.

13.23 All staff is trained to access, collect, and maintain confidential data and information.

13.24 All staff is supported in accessing ongoing professional development opportunities and trainings.

Section VI: Onboarding/Supervision

Training/Orientation for New Staff

New staff orientation expresses the importance of the new employee's role in achieving the mission of both the agency and the EIPP program. The purpose of orientation is to convey an understanding of what EIPP hopes to accomplish, why EIPP is utilizing specific strategies and interventions, and how the new employee can contribute to these efforts. An effective new staff orientation provides this framework and shows the new employee how they fit in with the EIPP team.

Key components of an effective new staff orientation can include:

1. New Employee Welcome Packet: A new employee welcome packet may include the following:
   - New hire paperwork;
   - The agency's mission, vision, history, organizational chart, and key strategic priorities;
   - Human resources related information such as payroll, policies, benefits, parking/commuting options, etc.;
   - Staff phone lists;
   - Union and ID Badges when appropriate;
   - Privacy and confidentiality requirements;
   - Mandated reporting requirements;
   - Workplace Safety & Violence Prevention Plan;
   - Other agency specific information and requirements.

2. Clear Communication: Establish a clear communication structure including expectations for both written and oral communication.

3. Facility Tour: A tour of the agency including designated workspace, emergency exits, team members' workspace including the supervisor, and location of office supplies orients the new employee to their work environment. Ensure time for computer orientation, discussion around troubleshooting equipment issues and accessing IT services.

4. Organizational Socialization: This can be accomplished by conveying institutional values, practices, and other aspects of the organizations culture. For example, what is the dress code, where do employees generally eat their lunch, etc.?

5. Required Reading: In addition to agency specific materials, all new employees are required to read the EIPP Practice Manual and are encouraged to ask any questions they may have.

6. Individual Staff Development (ISD) Plan: The ISD Plan is a tool to assist the new employee in career and personal development. Its primary purpose is to assist new employees in reaching both short and long term career goals and improve job

performance. It also serves the purpose of bridging the gap between the new employees' current skill set and the skill sets needed for the future of EIPP and the agency.

Components of the ISD Plan may include:

- On the job training;
- Mentoring;
- Job shadowing, including job shadowing EIPP staff from another site;
- Professional conferences & seminars;
- Formal classroom and/or web based training;
- Orientation with DPH staff.

Supervision

Supervision is an important relationship for health service providers, as it allows individuals to discuss and reflect on their work. Supervision helps providers conduct their work more effectively, contributes to program fidelity, and helps manage the emotions and stress that can be associated with the work. Although the identified supervisor may have specific expertise or knowledge to impart, supervision is an interactional process, with both parties actively contributing.

Due to the intensity of home visiting and working with families in this setting, EIPP staff should receive a minimum of one hour of weekly supervision per 1 FTE. Supervision may be in individual or group format, but it is highly recommended that staff participate in a combination of both individual and group supervision. Individual supervision allows the supervisor to tailor any necessary skill instruction to the needs of the staff member and offer more attention to their experience. Additionally, individuals may prefer to explore more sensitive topics and reflect on their personal reactions in individual supervision. However, group supervision provides an opportunity to discuss issues relevant to all team members and can be helpful to ensure the team is consistent in the delivery of EIPP practice components. Staff can also learn from one another and the group format can promote team unity and cohesion.

EIPP supervision should include elements of administrative, clinical, and reflective supervision. Administrative supervision relates to the oversight of regulations, policies, and procedures. This can include review of paperwork, monitoring productivity, and performance evaluation. Productivity and evaluation standards should be clear to each team member at the beginning of the supervisory experience, with regular feedback provided.

Clinical supervision relates to case discussion and the delivery of services to participating families. Specific activities can include planning for program goals, discussing strategies and progress, and teaching the supervisee program skills. Although direct skill instruction is likely most relevant to staff new to the program, it is also essential to attend to program fidelity for staff of all experience levels. It can be especially important to discuss strategies for overcoming barriers to program implementation.

Reflective supervision attends to the emotional content of the work and how personal reactions impact the work and the relationships. In reflective supervision, the supervisor is mindful of the parallel process in the relevant relationships; that is, the relationship between the parent and child

often replicates itself in the relationship between the parent and staff and then, finally, between the staff and supervisor. When engaging in reflective supervision, the supervisor should encourage the staff to engage in exploration and use open-ended questions to lead the staff to possible strategies.

All forms of supervision are necessary in the EIPP program, and in certain situations, such as onboarding a new team member to EIPP, a heavier focus on administrative and reflective supervision is appropriate. However, supervisors and staff should include a reflective component when possible, particularly when the relational aspect of the work is so critical.

Section VII: Programmatic Oversight

Caseload Management

EIPP vendors will develop an appropriate caseload management system that ensures high quality care and meets program standards of care. Program enrollment of new EIPP participants should be an ongoing activity with a minimum of 50 eligible pregnant and postpartum participants enrolled throughout a fiscal year. Program dosage with previous EIPP participants has ranged from 1 to 20 home visits with an average of 7 home visits per EIPP participant.

Form and Record Completion

Forms, Due Dates, and Responsible Party

Forms that MUST be completed and in the participant record within the designated time frames include:

1. Initial Enrollment Form
    - This form is NOT a referral form
    - Complete in full by the end of the first unit rate reimbursable home visit
    - Completed by any member of the EIPP team

2. Informed Consent
    - Complete by the end of the first unit rate reimbursable home visit
    - Completed by any member of the EIPP team

3. Comprehensive Health Assessment (CHA)
    - Initial CHA is complete by the end of the second unit rate reimbursable home visit
    - Subsequent CHAs are complete at the 2, 4, 6, 8, 10, and 12 months CHA/EI Screening postpartum home visits in conjunction with the ASQ-3
    - Must be completed by the MCH Nurse or the LMHC/Social Worker

4. Family Care Plan (FCP)
    - Complete by the end of the second home visit
    - Completed by any member of the EIPP team

5. Referral Checklist
    - Complete entire form by the end of the second unit rate reimbursable home visit
    - Update form after every subsequent home visit as appropriate
    - Completed by the EIPP team member who conducted home visit

6. Education Checklist
    - Complete after every home visit
    - Completed by the EIPP team member who conducted home visit

7. Home Visit Plan
    - Complete after every home visit
    - Completed by the EIPP team member who conducted home visit
    - Must be signed by the EIPP participant and the EIPP team member
    - If two members of EIPP team attended home visit together (i.e. MCH Nurse and CHW), only one home visit form needs to be completed and signed by both team members
    - The form must document not only the activities engaged in during the home visit, but also the planned next steps including the next scheduled home visit whenever possible

8. Participant and Child Postpartum Data Collection Forms
    - Begin to fill out after the child's birth
    - Update as soon as the data is collected
    - Completed by any EIPP team member

9. Ages and Stages Questionnaire (ASQ-3)
    - Complete at the 2, 4, 6, 8, 10, and 12 month CHA/EI Screening postpartum home visits in conjunction with the CHA
    - Must be completed by the MCH Nurse or the LMHC/Social Worker

10. Discharge Form
    - Complete at discharge
    - Completed by any EIPP team member
    - The discharge date must be the date directly following the date of the last face to face contact with the EIPP participant

11. EVS Check Documentation (only for EIPP participants on MassHealth insurance)
    - Begin to fill out after the first unit rate reimbursable visit
    - Update weekly at a minimum
    - Completed by any EIPP team member
    - Start a new form if/when an EIPP participant's MassHealth Plan changes (i.e. PPC to NHP)

Additional forms that MUST be in the medical record include:

1. Release of Information for the EIPP participant's OB/GYN and/or Primary Care Provider (PCP) or documentation as to why a release was not obtained
2. Progress notes documenting all phone calls, attempted contacts for EIPP participant and all contacts with collaterals
3. When applicable, print out of current EVS Check verification for all MassHealth members
4. When applicable, completed Prior Authorization Forms for all EIPP participants on a MassHealth MCO where unit rate reimbursement was requested from the MCO

Forms that MAY be in the medical record include:

1. Additional provider release information
2. Additional correspondence with providers

Contracting/Invoicing

Each selected vendor will receive two contracts. One contract will be a cost reimbursement contract for no more than $70,000. The intended use of the cost reimbursement base grant is to cover otherwise non-reimbursable costs such as Community Health Worker(s), outreach materials, supports for EIPP group services, transportation, supervision of staff and administration costs such as secretarial, management information system, or billing.

- At a minimum, $22,000 of the cost reimbursement contract must be used to support the role of the CHW including salary, benefits, travel, and training.
- A completed Personnel Summary Report must be included with all cost reimbursement invoices.
- DPH billing procedures through the EIM/ESM system require that contracted providers submit an invoice, on a monthly basis, for all services provided in the previous month.
- DPH requires that this invoice be authorized in EIM/ESM no later than the 14th day of the month, following service delivery. This includes a zero invoice if no services were provided.
- The only exceptions will be when the Bureau has been previously notified of extenuating circumstances and the request has been approved by the bureau contract manager. If corrections need to be made to previously submitted invoices, supplemental invoices must be submitted for the month in which the billing was originally submitted.
- All offsets must be reported for each UFR on the Invoice.
- Refer to the Provider Billing Booklet: Cost Reimbursement Policies and Billing in EIM for detailed invoicing requirements.

In addition, vendors will receive a Master Service Agreement (MSA) unit rate contract, based on the fees listed below. Based on available funding, unit rate reimbursement caps will be applied. Based on projected caseload, caps may range from $20,000 to $65,000.

- The MCH Nurses, LMHC/Social workers, and Nutrition and Lactation Consultants may bill against the MSA.
- Based on family need, the MCH Nurse, LMHC/Social Worker, Nutrition and Lactation Consultant may conduct a co-treatment visit. Co-treatment sessions that include the MCH Nurse and LMHC/Social Worker are limited to two billable prenatal – 6 months postpartum visit rates per session.
- Co-treatment sessions that include a nutritionist or a lactation consultant along with the MCH Nurse or LMHC/Social Worker are limited to one Nutrition & Lactation maximum rate per session.

The following is a description of the unit rate service types:

Initial CHA Visit:

- The EIPP Initial Visit is the first visit for an EIPP participant and must occur prior to any other EIPP service. The visit must be conducted by either the MCH Nurse or LMHC/Social Worker. The EIPP Initial Visit is not restricted to a set amount of hours. Providers will be reimbursed at $173.98 per visit. This rate is established pursuant to the Home Health Agency - Nurse Home Visiting rate under 114.3 CMR 3.00.

Prenatal - 6 Months PP:

- The EIPP Home Visit is not restricted to a set amount of hours. EIPP home visits are not allowed after the child turns 6 months of age. Providers will be reimbursed at the home health rate of $86.99 as described above.

CHA/ASQ Visit:

- This visit is not reimbursed under the EIPP DPH contract. It is an EI service. It is expected that this service will be billed to the appropriate insurer just like any other EI billable service. The child can be referred to EI for a CHA/ASQ screen six times between birth and one year of age, at 2, 4, 6, 8, 10 and 12 months postpartum. Each visit will be a CHA and developmental Early Intervention screening using the ASQ-3 and billed at a rate of $180.24 for a 1.5 hour visit.

Nutrition & Lactation:

- Based on family needs, Nutrition and Lactation Consultant services may be provided on an as needed basis. Providers will be reimbursed at a rate of $20.45 per 15 minute unit per EIPP participant. These visits are restricted to a one hour limit. Vendors will utilize modifiers of U1 to indicate a lactation consultant and U2 to indicate a Nutritionist. This rate is established pursuant to the rates for EI Program Services under 101 CMR 349.000.

Group Service:

- The EIPP group service is restricted to a two hour limit for each session with a minimum of 10 sessions being offered each fiscal year. Groups are facilitated by either the MCH Nurse and/or LMHC/Social Worker. The provision of group services to EIPP participants is allowed anytime between enrollment and discharge up to 12 months postpartum. Providers will be reimbursed at $7.85 per client per unit of 15 minutes of service provision. This rate is established pursuant to the rates for EI Program Services under 101 CMR 349.000.

The above noted rates are established pursuant to Commonwealth of Massachusetts regulations.

DPH reserves the right to fund additional contracts in the future based on new funding or gaps in services.

Data Collection

The EIPP Data System was developed by the DPH as a means of gathering and reporting information on the characteristics of families receiving services from EIPP, the utilization of perinatal and other parent and child health and human services, birth outcomes, and child health and development. In addition, the data system is an important tool for program monitoring and quality assurance.

Information transmitted to DPH from the EIPP Data System will be maintained in a database protected by passwords and accessible only to authorized staff. No identifying information will be included in any report prepared by DPH, unless required for data quality purposes.

Data is collected for each EIPP participant who is enrolled in the program. Every effort should be made to complete all items on the required EIPP forms as appropriate. Data collected from a family should be entered into the system within 5 working days of completing a home visit.

Data may be entered into the system at any time and should be transmitted to DPH at least once a week through the Interchange File Transfer website. An EIPP Data Manual and training on the use of the system is provided to all contracted vendors. EIPP contracted vendors will need to have Microsoft Access 2010 in order to utilize the EIPP Data System.

For additional information, please see the EIPP Data Manual.

Section VIII: Performance Monitoring

Fidelity Assessment

Fidelity to Process Indicators

Guidelines for form completion and service delivery determine a series of required EIPP process indicators. These are outlined below, organized by form, and dictate the minimum process requirements necessary to deliver the EIPP intervention as intended.

An automated report within the EIPP Data System must be run monthly by EIPP administrators to track provider fidelity across all active participants at an EIPP site. Fidelity should only be assessed on participants that have received an appropriate dose of service, meaning they have completed an initial CHA and received at least one additional home visit. A total fidelity score is calculated by dividing the number of completed items (i.e., items marked "yes" or "n/a"), by 12, which is the total number of process indicators. The goal integrity score is 80%, meaning at least 10 indicators must be completed.

EIPP Initial Enrollment Form

- Was the Initial Enrollment form completed by the end of the first unit rate reimbursable home visit? (Yes/No/N/A)

Comprehensive Health Assessment (CHA), including Ages & Stages Questionnaire (ASQ-3)

- Was the initial CHA completed by the end of the second unit rate reimbursable home visit? (Yes/No/N/A)
- Was the initial CHA completed by either the MCH Nurse or LMHC/Social Worker? (Yes/No/N/A)
- Were at least 9 out of 14 Key Assessment Areas assessed on the completed initial CHA? (Yes/No/N/A)
- Were a minimum of two CHAs completed by discharge? (Yes/No/N/A)

Family Care Plan (FCP)

- Was the FCP completed by the end of the second unit rate reimbursable home visit? (Yes/No/N/A)

Referral Checklist

- Was the Referral Checklist completed by the end of the second unit rate reimbursable home visit? (Yes/No/N/A)

Education Checklist

- Was an Education Checklist completed after every home visit? (Yes/No/N/A)

Participant & Child Postpartum Data Collection Forms

- Was the Participant Postpartum Data Collection form completed by discharge? (Yes/No/N/A)
- Was the Child Postpartum Data Collection form completed by discharge? (Yes/No/N/A)

Discharge Form

- Was a Discharge Form completed at discharge? (Yes/No/N/A)
- Did the Discharge Form reflect a discharge date directly following the date of the last face to face contact with the EIPP participant? (Yes/No/N/A)

Total Fidelity Score = # Yes + # N/A _____ /12 = _____%

Fidelity to Progress Indicators

The following checklist should be used by EIPP administrators to assess progress fidelity quarterly. During quarterly fidelity reviews, 20% or a maximum of 10 active participant charts should be selected at random. For example, if an EIPP site has 30 active participants, charts for 6 of these participants would be selected at random and reviewed. Fidelity should only be assessed on participants that have received an appropriate dose of service, meaning they have completed an initial CHA and received at least one additional home visit.

The checklist should be completed for each chart reviewed during the quarterly review process and integrated within the supervision process. Review during supervision will both ensure the integration of fidelity assessment within the existing framework and will allow for ongoing professional development and training. Data collected for each checklist will be entered into the EIPP Data System for cross-site fidelity review. A total fidelity score would be calculated by dividing the number of completed items (i.e., items marked “yes” or “n/a”), by 17, which is the total number of progress indicators. The goal integrity score would be 80%, meaning at least 14 indicators must be completed.

Participant Name: _____ Date: _____

EIPP Progress Fidelity Checklist

Item	Scoring Options	Notes/Comments
1. Was the Informed Consent form completed by the end of the first unit rate reimbursable home visit?	☐Yes ☐No ☐N/A	
2. Does the FCP reflect areas of concern as identified in the initial CHA?	☐Yes ☐No ☐N/A	
3. Does the Referral Checklist reflect the needs identified in the initial CHA?	☐Yes ☐No ☐N/A	
4. Did the participant receive an EI referral if indicated on any of the ASQ-3s?	☐Yes ☐No ☐N/A	
5. Was a Home Visit Plan completed after each home visit?	☐Yes ☐No ☐N/A	
6. Was each Home Visit Plan signed by both the EIPP Participant and the team member conducting the visit?	☐Yes ☐No ☐N/A	
7. Do all Home Visit Plans completed reflect documentation of the activities engaged in during the home visit and also the planned next steps?	☐Yes ☐No ☐N/A	
8. Do the documented activities engaged in during home visits reflect priorities outlined in the FCP?	☐Yes ☐No ☐N/A	
9. Do next steps determined during home visits reflect priorities outlined in the FCP?	☐Yes ☐No ☐N/A	
10. Does the Education Checklist address priorities identified in the initial and subsequent CHAs?	☐Yes ☐No ☐N/A	
11. Were subsequent CHAs completed at the following time points?	2 months? ☐Yes ☐No ☐N/A 4 months? ☐Yes ☐No ☐N/A 6 months? ☐Yes ☐No ☐N/A 8 months? ☐Yes ☐No ☐N/A 10 months? ☐Yes ☐No ☐N/A 12 months? ☐Yes ☐No ☐N/A	
12. Were each of the subsequent CHAs completed by either the MCH Nurse or LMHC/Social Worker?	☐Yes ☐No ☐N/A	
Total Score	**# Yes + # N/A ____ / 17 = _____%**	

Fidelity to Administrative/Implementation Processes

In addition to participant-level fidelity indicators, it is important to have a series of measures to assess whether administrative processes are being implemented as intended across agencies. Included in the checklist below are the primary administrative and procedural components of EIPP practice. These measures should be utilized by EIPP administrators as a regular self-check and by DPH to assess site-level implementation of the EIPP model.

Committee on Perinatal & Early Childhood Health

- ☐ Active Committee roster
- ☐ Documentation of regular Committee meetings and attendance

EIPP Groups

- ☐ Documentation of group schedule (at least one, 10-week group session annually)
- ☐ Documentation of group roster and attendance
- ☐ Curriculum focused on topic related to EIPP program goals

Supervision

- ☐ Documentation of weekly supervision schedule per 1 FTE for all EIPP staff
- ☐ Documentation of weekly supervision attendance

Training and Onboarding

- ☐ Documentation of staff qualifications and role description
- ☐ New Employee Welcome Packet developed to meet DPH and site requirements
- ☐ Documentation of Individual Staff Development (ISD) Plan for each active staff

Fidelity Assessment

- ☐ Documentation of monthly process report generation
- ☐ Documentation of quarterly progress checklists for 20% of active clients

Continuous Quality Improvement (CQI)

- ☐ Pending final CQI plan

Performance and Outcomes Assessment

- ☐ Documentation of completion of annual Quality Performance Evaluation
- ☐ Pending final outcome assessment protocol

Data Systems

- ☐ Protocol for ensuring data entry within 5 working days of home visit completion

Site Visits

Site visits are conducted annually with each of the EIPP vendors. The site visits are meant to monitor and evaluate program compliance with the DPH contract and to assure quality services for all families participating in EIPP across program locations.

Site visits cover the following areas:

- Discussion of best practices and challenges;
- Updates from the state and national perspective on maternal and child health initiatives;
- Compliance with the EOHHS Human Service Workers Violence Prevention & Response Plan Guidelines (Section 30 of Chapter 3 of the Acts of 2013 and Executive Order 442 Establishing a Policy of Zero Tolerance for Workplace Violence) including documentation of required staff training;
- Compliance with Culturally & Linguistically Appropriate Services (CLAS) standards;
- Required Staff Supervision;
- Required Staff Training & Credentials;
- Committee on Perinatal & Early Childhood Health membership, meeting schedule, and minutes; and
- Record review of 20 randomly selected files.

Site visit findings will be shared at the close of the visit and in a written report highlighting best practices and areas of concern.

Continuous Quality Improvement

[Protocol to be inserted once finalized]

Appendices

Appendix 1. Performance Measures Defined

Performance Measure #1: Percentage of EIPP participants served by the program who were enrolled prenatally.

Numerator: Number of participants who enrolled prenatally ('Pregnant' is selected under 'Status at Enrollment' on the Enrollment tab in the EIPP Data System).

Denominator: All active EIPP participants.

Performance Measure #2: Percentage of families served by the program who had at least five visits by program discharge.

Numerator: Number of participants who received at least five visits prior to discharge (Visits are designated in the home visit folder in the EIPP Data System).

Denominator: All EIPP participants who have a program discharge date entered into the EIPP Data System.

Performance Measure #3: Percentage of families served by the program who had a Comprehensive Health Assessment (CHA) completed by the end of the second face to face visit.

Numerator: Number of participants with a CHA completed by the end of the second face-to-face visit. (A Completed CHA is defined as 9 out of the 14 key assessment areas receiving a value of a 1, 2, or 3.)

Denominator: All active EIPP participants with the first home visit designated as IV-1 and if and when applicable, the second home visit designated as IV-2.

Performance Measure #4: Percentage of families with a concern identified on a CHA who received education and/or a brief intervention.

Numerator: Number of participants who received education/brief intervention for an identified concern.

Denominator: All EIPP participants who have received at least two home visits and had a concern identified on a CHA and have been discharged from the program. (For each of the 14 key assessment areas on the CHA, a concern identified is defined as the key assessment area receiving a score of a 1 or a 2. In addition, a corresponding topic has been checked off on the health education checklist.)

Performance Measure #5: Percentage of postpartum participants who had a postpartum visit with a health care provider between 21 and 56 days after birth.

Numerator: Number of participants who completed a postpartum visit between 21 and 56 days of delivery.

Denominator: All active EIPP participants who are at least 57 days postpartum based on the child's birth date as entered into the EIPP Data System.

Note When the EIPP Data System records a response of 'No' to the question 'did visit occur between 21 and 56 days postpartum?' and there is a reason checked off, exclude case from the denominator.

Performance Measure #6: Percentage of children who had a 2-month Ages & Stages Questionnaire completed with the child's primary caregiver(s).

Numerator: Number of EIPP children with ASQ scores entered into the EIPP Data System.

Denominator: All active EIPP children who are 80 days old or older based on the child's birth date as entered into the EIPP Data System.

Note When the EIPP Data System records a response of "No" to the question 'was an ASQ-3 completed?' and there is a reason checked off, exclude case from the denominator.

Performance Measure #7A: Percentage of children who were fed exclusively breast milk at birth.

Numerator: Number of children fed exclusively breastmilk at birth. (An answer of "Yes" to the question in the EIPP Data System that asks 'is EIPP child being fed exclusive breast milk at birth?')

Denominator: All active EIPP participants who were enrolled in the program prenatally and whose child is four days old or older based on the child's birth date as entered into the EIPP Data System.

Note Enrolled prenatally is defined as the "pregnant" option being selected under "status at enrollment" on the enrollment tab in the EIPP Data System.

Performance Measure #7B: Percentage of children who were fed any amount of breast milk at 6 months postpartum.

Numerator: Number of children who were fed any breastmilk at 6 months of age. (An answer of "Yes" to the question in the EIPP Data System that asks 'is EIPP child being fed any amount of breast milk at 6 months postpartum?')

Denominator: All active EIPP participants whose child is 183 days old or older based on the child's birth date as entered into the EIPP Data System.

Performance Measure #8: Percentage of EIPP participants who had a documented reproductive life plan that includes family planning counseling and choice of contraception by 2 months postpartum.

Numerator: Number of participants with a documented reproductive life plan by two months postpartum. (On the health education checklist, the category of 'family planning' under the second key assessment area of 'women's health' has one of the four values checked off AND a contraception method choice has been checked.)

Denominator: All active EIPP participants who are 70 days postpartum or more.

Performance Measure #9: Percentage of EIPP participants who were screened for depression using the Edinburgh Postnatal Depression Scale (EPDS) within 70 days of enrollment.

Numerator: Number of participants screened for depression within 70 days of enrollment. (An EPDS score is entered into the EIPP Data System under the CHA Key Assessment Area #11 for an active EIPP participant.)

Denominator: All active EIPP participants who have been enrolled in the program for at least 70 days based on the enrollment date.

Performance Measure #10: Percentage of EIPP participants identified with depression and/or other mental health condition on the CHA and/or EPDS who received mental health services by program discharge.

Numerator: Number of participants who received mental health services by program discharge. (On the referral checklist under the key assessment area of emotional health, at least one category has been checked off as 'Already Receiving' or as 'Referred' with a referral outcome of 'Enrolled/Receiving' noted.)

Denominator: All EIPP participants who have been assessed as having an EPDS score of 13 or higher under the key assessment area #11 of emotional health on any CHA and have been discharged from the program.

Performance Measure #11: Percentage of EIPP participants who were screened for intimate partner violence (IPV) using a validated screening tool within 70 days of enrollment.

Numerator: Number of participants screened for IPV within 70 days of enrollment. (An IPV score is entered into the EIPP Data System under the CHA Key Assessment Area #10 for an active EIPP participant.)

Denominator: All active EIPP participants who have been enrolled in the program for at least 70 days based on the enrollment date. Exclude from the denominator if there is documentation that someone over the age of 2 years was present at the time the screen was to be administered.

Performance Measure #12: Percentage of EIPP participants who were screened for alcohol, tobacco and other drugs (ATOD) using a validated screening tool within 70 days of enrollment.

Numerator: Number of participants screened for ATOD within 70 days of enrollment. (An ATOD score is entered into the EIPP Data System under the CHA Key Assessment Area #9 for an active EIPP participant.)

Denominator: All active EIPP participants who have been enrolled in the program for at least 70 days based on the enrollment date

Performance Measure #13: Percentage of participants who most often placed their children on their backs to sleep at 2 months of age.

Numerator: Number of participants who most often placed their children on their backs to sleep at 2 months of age. (For all active EIPP children who are at least 70 days old or older, the option "back" is selected to the question "in what position do you most often lay your child down to sleep?")

Denominator: All active EIPP participants whose children are at least 70 days old or older based on the child's birth data as entered in the EIPP Data System.

Appendix 2. EVS Check Documentation Form

What is this form? EVS Check Documentation Form

Who completes it? Any member of the EIPP team.

When do I use it? The EVS Check Documentation is completed after the first unit rate reimbursable home visit with a participant and updated weekly at a minimum.

How do I use it? This form is only for EIPP participants on MassHealth insurance. Start a new form if/when an EIPP participant's MassHealth Plan changes (i.e. PPC to NHP).

Early Intervention Parenting Partnerships Program
EVS Check Documentation Form

EIPP Participant's Information:

Participant's Last Name: Participant's First Name: Date:

_____ _____ ___/____/___

Type of Health Insurance:

MassHealth PCC, ID#:_____

MassHealth MCO, ID#:_____

Which MCO (circle one): NHP Fallon BMC Tufts HNE

MCO ID # :_____

Weekly EVS Check Documentation

Date EVS Done:_____ Initials of Person Conducting EVS Check:_____

Date EVS Done:_____ Initials of Person Conducting EVS Check:_____

Date EVS Done:_____ Initials of Person Conducting EVS Check:_____

Date EVS Done:_____ Initials of Person Conducting EVS Check:_____

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Date EVS Done:_____ Initials of Person Conducting EVS Check:_____

Date EVS Done:_____ Initials of Person Conducting EVS Check:_____

A new EVS Check Documentation Form must be used when/if the EIPP participant's health insurance status changes